C+D

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24 October 2009

1859-2009 Celebrating 150 years in pharmacy

Will you be getting the jab?

PCTs split over swine flu vaccination plans

See page 5

PLUS

Commitment 6:

We will support those seeking advanced or specialist levels of practice.

On the 7th September we announced a series of commitments that underline how the professional leadership body (PLB) intends to become the body you have asked for.

Our sixth commitment is to 'support those seeking advanced or specialist levels of practice.'

Here are the actions we will take over the next 100 days to demonstrate our commitment:

a. Work with specialists within the profession to develop standards, frameworks and nationally recognised awards for advanced and specialist levels of practice - with community pharmacy being a key area of focus.

b. Trial online networks for internal and external specialist groups in October, ahead of piloting and rollout to further groups.

To keep an eye on our progress, suggest future actions we can take, and to read about the rest of the commitments in full, visit **www.pharmacyplb.com**

COMMITMENT TO PHARMACY

'It is pleasing that the new body will provide us with the right resources so we can develop and through that, offer the best services that enhance patient care.'

Gautam Paul, Hospital Pharmacist and Teacher Practitioner

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> THE LAST TIME I CHECKED, PATIENT CONTACT WAS A FAIRLY COMMON OCCURRENCE IN PHARMACIES

Extraordinary efforts by manufacturers and the government have culminated in the rollout of a swine flu vaccination this week.

More than 11 million people will be in the first wave of vaccinations as hospitals and later GP surgeries start delivering the programme.

And in a letter to PCTs, GPs and pharmacists, signed by England's chief medical, nursing and pharmaceutical officers, the importance of vaccination for frontline health workers is clear.

This makes perfect sense. The sharp end of the NHS will be swamped with patients if the pandemic worsens this winter, and without a healthy and fully staffed workforce, services could be overwhelmed. The consequences do not bear thinking about.

Back in August, C+D revealed that the local NHS would be given the power to decide which pharmacists received the vaccine on the basis of clinical contact with patients. And the DH added that pharmacists "directly involved" in patient care would be regarded as frontline healthcare workers and be offered the vaccine (C+D, August 29, p6).

So it comes as some surprise that a few PCTs will not be offering the vaccine to pharmacists in their priority rollout (p5). One said that only pharmacists "contracted to deliver services previously delivered by doctors and nurses" counted as frontline healthcare professionals. Excuse me, but the last time I checked, patient contact was a fairly common occurrence in pharmacies; with six million people visiting them daily, contact is hard to avoid.

We should make it clear that the overwhelming majority of PCTs consider pharmacy to be a key service worthy of inclusion in their priority vaccination plan, but for the pharmacists who work in the minority of PCTs who think otherwise, they have every right to feel let down. They provide no less a healthcare service than their colleagues across the country, so why be treated any differently?

Some PCTs may regard the dispensing service provided by pharmacy as non-contact. But this essential service is not a stand alone operation, coming as it does with advice on taking prescription medicines, information on OTC medicines and help with associated conditions. It may be a brief consultation, but it's no different from consulting with any other frontline healthcare worker.

The production of a vaccine in time for the winter has been a remarkable effort that shows how effectively the government, the NHS and stakeholders can work together. It would be a shame to see that effort marred by vaccination plans that allowed local decision making to designate some frontline healthcare workers less worthy than others.

Gary Paragpuri, Editor

Pfizer renews its distribution deal with Alliance Healthcare

Renegotiation will see wholesaler continue DTP deal from March next year

Chris Chapman
cchapman@cmpmedica.com

Alliance Healthcare will continue as the distributor of Pfizer medicines from March 2010, C+D can reveal.

The direct-to-pharmacy (DTP) deal, the first of its kind in the UK, was met by hostility from both pharmacists and wholesalers when first launched in March 2007.

However, a Pfizer spokesperson confirmed the manufacturer will continue to use Alliance Healthcare as its sole distributor under a renewed deal.

He said: "Alliance Healthcare is the sole direct-to-pharmacy logistics service provider for Pfizer medicines in the UK and, from March 2010, Pfizer will continue to use Alliance Healthcare to deliver its medicines."

Speaking exclusively to C+D, Alliance Boots pharmaceutical wholesale division chief executive Ornella Barra said the wholesaler had been confident of renegotiation.

She said: "The service offered by Alliance Healthcare is perfect. The pharmacies are happy, Pfizer is very happy about the service and I am very confident it will continue."

Rival wholesaler Phoenix said it would be interested in partnering with the pharma giant should Pfizer wish to change its model. Wholesaler AAH said it was "not aware" Pfizer had been interested in re-tendering its DTP contract.

In January, a Pfizer consultation with pharmacists revealed 74 per cent of respondents were unhappy with the DTP system. The Pfizer spokesperson told C+D the manufacturer was "continually reviewing our arrangements in order to maintain and further improve the high level of service provided to our customers".

Two years ago DTP schemes survived a challenge over possible restriction of competition, with the Office of Fair Trading ruling "manufacturers should be free to choose the distribution method they consider to be most efficient".

More from C+D's Conference
See p26

Both Pfizer and pharmacies are happy with Alliance Healthcare's service, the wholesaler's chief executive Ornella Barra said

"I want to see the same services and layout in different countries"

Ornella Barra on Alliance Boots' global ambitions – see p12

PSNC urges caution over MUR probe

PSNC has told pharmacists not to hand over MUR forms to PCTs just yet as part of a counter fraud investigation. The NHS Counter Fraud and Security Management Service has written to PCTs' finance directors to request MUR forms from June 2009.

But PSNC has told contractors not to comply, as doing so could threaten patient confidentiality. The organisation has made a legal challenge over the matter.

PSNC head of regulation Steve Lutener said it was more important to be cautious about a possible breach of patient confidentiality than to comply with the NHS investigation. "We are waiting to hear from the Department of Health lawyers on their views on this disclosure of patient information."

The MUR recall had been issued over concerns that the MUR process could be susceptible to fraud, said Jonathan Mason, the DH community pharmacy tsar.

Although the majority of pharmacists were providing a professional service, he said, there could always be "one or two bad apples". Mr Mason said there had been concerns about the quality of some MURs and added: "There are people who are suspicious of any business activity."

PSNC has said the exercise is not in response to any specific suspicions about contractors. Under the terms of service, PCT officials may inspect pharmacies' records, PSNC stressed. However, protecting patients' details meant anonymised documents were favoured for most monitoring. **JC**

Future regulator's standards open to views from profession

Grassroots pharmacists can now have their say on the standards that the future pharmacy regulator will set for the profession.

The overarching healthcare regulator has launched a 12-week public consultation on the draft standards for the General Pharmaceutical Council (GPhC).

GPhC chief executive designate Duncan Rudkin encouraged all pharmacists to submit their views on the standards, which will cover:

- pharmacy owners, superintendents and premises
- conduct, ethics and performance
- proficiency
- education and training
- CPD.

"The standards will affect the working lives of all registrants and, ultimately, the quality of services they provide to the public on a day-to-day basis," Mr Rudkin said.

The Council for Healthcare Regulatory Excellence (CHRE) is hosting the consultation so that it can be completed alongside the parliamentary process to establish the GPhC, in order that the GPhC is ready to take over regulation from the RPSGB in spring 2010 as scheduled.

The consultation is open until January 12, 2010, at www.chre.org.uk/consultation/175 **JR**

Coming soon to a pharmacy near you: electronic prescriptions
See p22

Pharmacists sidelined as swine flu vaccine arrives

Some trusts omit pharmacy from first wave of inoculations

Chris Chapman
cchapman@cmpmedica.com

Despite NHS advice, some English PCTs have left pharmacy out of vaccination plan

Pharmacists are still on the fringe of some PCTs' swine flu vaccination plans, despite industry bodies urging individuals to accept the vaccine if offered.

As NHS acute trusts received their first deliveries of the H1N1 vaccine this week, a joint statement by the RPSGB, CCA, PSNC and NPA encouraged pharmacists to accept the jab if available.

However, C+D can reveal a minority of PCTs in England have chosen to ignore explicit advice from the Department of Health (DH) to include pharmacists in their priority vaccination schemes. In information obtained under the Freedom of Information Act, C+D was told by several trusts that pharmacists would be left out of the first wave of inoculations.

Herefordshire PCT said pharmacists would not receive the vaccine in the priority group rollout, while Middlesbrough PCT said only pharmacists "contracted to deliver services previously delivered by doctors and nurses" counted as "staff directly involved in patient care". Both responses were received weeks after a joint letter from national director for NHS flu resilience Ian Dalton and PSNC chief executive Sue Sharpe stated: "Those pharmacists and their clinical staff... who have regular clinical contact with patients... will be eligible for the vaccine".

DH community pharmacy tsar Jonathan Mason echoed calls for pharmacists to accept the vaccine, adding that he believed most pharmacists would be offered the jab.

He said: "The feedback I've had from meetings around the country is that most PCTs have included pharmacy in their planning."

The DH guidance to include pharmacists in vaccination plans was issued after C+D revealed pharmacists had been left off the DH list of professionals for priority vaccination (C+D, August 22, p6).

Submit CPD or face investigating committee, RPSGB warns members

The Royal Pharmaceutical Society has warned pharmacists to supply CPD records when asked or face referral to its investigating committee.

The rebuke comes just three months after the RPSGB vowed to take a sympathetic view of lapsed record keeping.

The latest announcement comes after around 10 per cent of pharmacists ignored requests to submit CPD since the call and review programme launched in July.

In a statement, the Society stressed failure to supply CPD records when requested was a breach of the code of ethics for practising pharmacists.

Jane Flint, RPSGB CPD lead, said. "Failure to comply with the request to submit CPD records will result in referral to the Society's fitness to practice department." However, the RPSGB would show leniency to those who were struggling to get submissions in on time, she added.

She said: "The Society is keen to take a supportive approach and would encourage registrants who are having difficulty in meeting the submission deadline to contact the Society as soon as possible."

Pharmacists are given six weeks to return records when requested by the Society.

Registrants must show a minimum of nine entries a year from March 2009 under the checks.

Up to 200 pharmacists a week have been asked to submit CPD records since call and review launched.

The majority of pharmacists had responded "positively" to CPD checks, the Society stressed. **MG**

Have you been asked to submit your CPD for review?
mgosney@cmpmedica.com

In brief

RP talks underway

Issues for both pharmacists and businesses arising from the responsible pharmacist regulations have been discussed by the CCA and the PDA. The organisations announced they have begun a series of discussions on matters of "mutual concern".

Pramipexole prolonged

Mirapexin (pramipexole) is now available as a once-daily prolonged release tablet, manufacturer Boehringer Ingelheim has announced. Immediate release pramipexole will continue to be available.

Efexor tablets stopped

Efexor 37.5mg and 75mg tablets have been discontinued. Manufacturer Wyeth said the decision was made following the loss of patent exclusivity on the tablets. Efexor XL capsules will remain available.

Flucloxacillin sugar-free

Flucloxacillin oral solution is now available sugar-free. Manufactured by Actavis, the formulation is available in both 125mg/5ml and 250mg/5ml strengths.

Vaccines text reminders

Wyeth Vaccines has launched a text message service to remind parents about their children's immunisation schedules. The reminder service is also available to those in the at-risk groups for seasonal flu.
www.wyethvaccines.co.uk

NPA: write to your MP

The NPA has invited pharmacists to write to their MP to suggest they attend their Ask Your Pharmacist event at Westminster on November 4.
www.npa.co.uk

Chronic conditions talks

A service for long-term conditions is the "main item" on the contract negotiations agenda in Scotland. A group has been set up to devise a payment model for the chronic medication service (CMS), contract negotiator Community Pharmacy Scotland reported.
www.chemistanddruggist.co.uk

Sinemet shortage

Merck Sharpe & Dohme Ltd has announced a shortage on all doses of Parkinson's treatments Sinemet and Sinemet CR. The shortage is related to a change in the source of supply for key ingredients in the drugs, the firm said. Normal supply is not expected until 2011. For emergency supply enquiries, call 01992 462094

Ideas on quality sought

Pharmacists have been asked by a government chief to give their ideas on how the NHS should improve quality and efficiency. **www.chemistanddruggist.co.uk**

Swine flu praise

The UK has been successful at controlling the swine flu pandemic, according to the government. Public health minister Gillian Merron praised the NHS, Health Protection Agency and other organisations that helped to limit the initial wave of infection.

Pfizer/Wyeth deal

Pfizer has completed the acquisition of fellow manufacturer Wyeth, first announced in January this year. The deal will give Pfizer a more diverse product portfolio including vaccines, consumer healthcare and animal health, according to Pfizer.

Pre-diabetes time bomb

Seven million people in the UK have impaired glucose regulation (IGR), or pre-diabetes, according to research by the charity Diabetes UK. The condition makes them up to 15 times more likely to develop Type 2 diabetes but it can be reversed with lifestyle changes.

Superdrug ups flu stocks

Superdrug has doubled its order of seasonal flu vaccine to meet expected demand caused by this year's swine flu outbreak. **www.chemistanddruggist.co.uk**

Clarification

C+D would like to clarify that Lloydspharmacy's head of network dispensing development is Mike O'Donnell, not Mark O'Donnell as stated in C+D, October 17, p10-11.

Pharmacy bodies yet to be convinced by EPS

Organisations say they won't commit until they see pilot results

Zoe Smeaton
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The pharmacy jury is out on whether EPS will be good for the sector

Pharmacy bodies have refused to say whether they think the electronic prescription service (EPS) will bring benefits for pharmacy or not.

PSNC, the NPA and the RPSGB all seemed unsure whether the service would be good for the sector in responses to questions from C+D.

The comments have concerned system suppliers, who suggested the pharmacy bodies should have raised their doubts far earlier in the service's development.

The NPA said until it had seen the impact of EPS release 2 (being piloted) on operational functionality in pharmacies it would be "difficult to evaluate the overall benefit of EPS". PSNC agreed that it was "too early" to confirm whether EPS would have an adverse impact on the safe and efficient supply of medicines.

The RPSGB said it believed EPS had the "potential" to improve dispensary workflow.

Ian Taylor, commercial director at Rx Systems, told C+D the lack of support was concerning given how much money all system houses had invested in technology. "We've done what we believed the professional bodies wanted as part of their negotiations," he said.

Martin Jones, commercial manager at Positive Solutions, agreed: "As system suppliers we would like them to be rather more enthusiastic about it."

The suppliers all backed EPS, saying it would bring benefits for pharmacy, for example in reducing inaccuracies and automating script payments.

Suppliers boycott NPA forum

System suppliers have boycotted an NPA meeting on EPS in a fresh blow to relations between the parties.

C+D understands that suppliers including Cegedim Rx and Rx Systems declined to accept an invitation to the NPA's supplier forum on September 30.

One supplier told C+D they had "disengaged with the NPA" saying they felt the pharmacy professional bodies still tended to blame suppliers for all EPS issues. The NPA said all suppliers would be informed of ongoing work and that the latest supplier forum had seen a "productive discussion" about taking IT forwards. ZS

BAPW seeks meeting with minister over claim

The pharmacy minister is investigating possible restriction of trade by wholesalers, he revealed in parliament last week.

Wholesalers' trade body, BAPW, has requested a meeting with Mike O'Brien, and the MP whose question prompted his comments, to clarify their concerns.

Mr O'Brien told the House: "There are concerns about the way in which wholesalers are now using, in effect, funnels to restrict the ability of some of the pharmacy retailers to get access to drugs, thereby driving up the price. I am concerned about this, and we need to watch it carefully."

The comment was prompted by a question from Labour MP Rob Marris, who named Phoenix and Alliance Healthcare as perpetrators of an "apparent restraint of trade" to "small, new and independent pharmacy retailers".

Someone in Mr Marris's south-west Wolverhampton constituency trying to open a new pharmacy had been refused wholesaler accounts, Mr Marris told C+D. Yet the constituent had not asked for credit and was able to pay "a considerable amount of money upfront".

But Alliance Healthcare managing director Jeremy Main insisted it was "absolutely committed to serving and supporting independent pharmacy", the "bedrock" of its business.

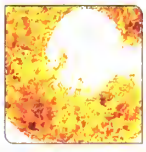
Phoenix chief executive Paul Smith said its trading terms reflected business risk in a "fair and open manner". He added: "To suggest that we refuse to supply anyone for the benefit of our own retail chain is at best misinformed and certainly mistaken."

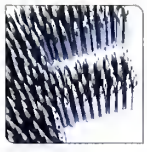
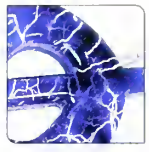
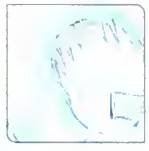
The BAPW was "not aware" of the Department of Health "overtly monitoring anything", executive director Martin Sawer told C+D.

He said: "With the supply chain, rumours and accusations fly in all directions and getting to the truth is often tricky but important." **JR**

FREEZING PAIN

Have any of your patients described their pain as feeling ice cold? Chronic pain that is hard to treat can become frustrating. You can aid your patients by asking them to describe their pain, which will help you to identify those with neuropathic pain.



Action on pain!

BackCare
The Charity for Healthier Backs

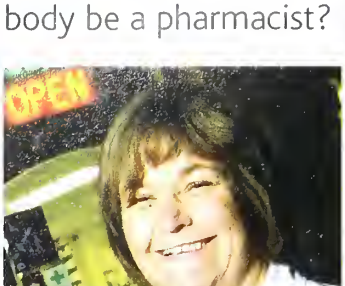
PAIN CONCERN

Trigeminal Neuralgia Association UK

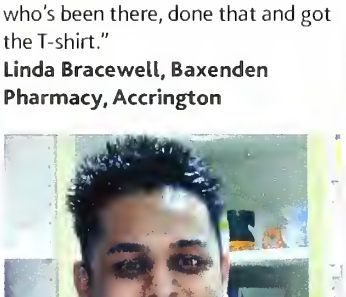
Pfizer

Dispensary talk

Should the chief executive of the new professional leadership body be a pharmacist?



"Absolutely and unequivocally. And preferably someone who has some form of active practice – I can't think of a better advocate than someone who's been there, done that and got the T-shirt."
Linda Bracewell, Baxenden Pharmacy, Accrington



"Not necessarily, no. Pharmacists are good at what they do – they're scientists. They're not all all-round businessmen and sometimes an external manager can be beneficial."
Amish Patel, Hodgson Pharmacy, Dartford

Web verdict

Yes 95%

No 5%

Armchair view: The result is a landslide: pharmacists want a pharmacist at the helm of their new professional leadership body when it comes into being next year.
Next week's question:
Have you been offered the swine flu vaccine by your PCT? Vote at **www.chemistanddruggist.co.uk**

Pharmacy in majority of PCT vascular check plans

Fifty four per cent of trusts want checks carried out by contractors

James Clegg

Over half of PCTs who have drawn up vascular screening plans want to commission checks through pharmacies, a survey has revealed.

Fifty four per cent of trusts pushing ahead with the checks intended to do so via local contractors, a PSNC survey found.

PSNC praised hard working LPCs for securing pharmacy's role in the NHS programme to screen all over-40s for vascular diseases.

PSNC head of NHS services Alastair Buxton said: "Naturally I would like to see that figure at 100 per cent, but at this early point it is positive progress."

The survey found 95 per cent of LPCs had discussed vascular checks with PCTs, with LPCs making the initial enquiry in eight out of 10 cases.

However, even in areas where LPCs had lobbied to provide the checks, there was no guarantee of success, PSNC stressed. Mr Buxton said: "Being pro-active is obviously a major factor in getting commissioned but there are still examples of enthusiastic LPCs not getting anywhere with primary care trusts."

The survey also showed that 90 per cent of contractors were keen to get involved with vascular checks. But, out of this figure, 45 per cent also possessed reservations, mainly centred on workload.

Mr Buxton argued that this would change as the service developed. He said: "The thing is having confidence to invest in staffing levels to provide this service.

"These will remain long-term contracts and that means people can have confidence to make that investment."

The survey found GPs were the top choice provider for PCTs drawing up vascular screening plans, with 73 per cent being factored into delivery.

A C+D LPC survey earlier this month (C+D, October 3, p14) found vascular checks among the top services contractors wanted to see PCTs commission more from pharmacy.

PSNC survey of LPCs

36% of PCT areas have a permanent or ongoing/ completed vascular screening pilot service

54% either are using or intend to use community pharmacy to deliver checks

45% LPCs rate 45 per cent of contractors as very keen to get involved and 45 per cent keen but with reservations

PLB members to decide on non-pharmacists

Members of the new professional leadership body (PLB) will get to vote on whether non-pharmacists will be allowed to join, the RPSGB has confirmed.

The Society Council considered four classes of membership for the PLB earlier this month. These included student and associate member categories for non-pharmacists. But C+D now understands pharmacists will vote on whether these groups will exist when the PLB forms.

Society adviser Michele Savage said: "Members of the professional leadership body will vote on all new membership categories."

If the special resolution vote is passed, pharmacy graduates who have never registered as a pharmacist would be free to join the PLB and use the post-nominal AMRPharmS.

However, the proposal has come under fire from some RPSGB Council members. Council member Dorothy Drury, who opposed the associate member category during the Council meeting earlier this month, branded the proposal "silly", stating the idea "hasn't been thought through very well".

She said: "I think the professional body should be for the fully qualified. Postnominals aren't something you buy, they're something you earn by the pre-reg year... it could be confusing to the public." **CC**

Should the PLB be reserved for pharmacists only?
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England eyes Welsh shake-up

A planned revamp of pharmacy services in Wales could bring benefits for the sector in England, a government expert has said.

Jonathan Mason, the DH community pharmacy tsar, said succesful service developments in Wales could be used as evidence to support commissioning in England.

The comments follow a Welsh strategic delivery group's proposals to set up four directed enhanced services under a review of pharmacy services.

Russell Goodway, chief executive of Community Pharmacy Wales, said the proposals could make establishing frameworks and agreeing on services easier in Wales. **ZS**

Read more about future plans for pharmacy in Wales on p24

Keep their neuropathic pain at bay

Rapid pain relief within 1 week, typically by day 2[1–4]

Sustained pain relief, for up to 2 years[3]

Relief from neuropathic pain-related sleep interference[1,2]

Lyrica® (pregabalin) Prescribing Information
Refer to Summary of Product Characteristics (SmPC) before prescribing.
Presentation: Lyrica is supplied in hard capsules containing 25mg, 50mg, 75mg, 100mg, 150mg, 200mg, 225mg (for Generalised Anxiety Disorder only) or 300mg of pregabalin. **Indications:** Treatment of peripheral and central neuropathic pain in adults. Treatment of epilepsy, as adjunctive therapy in adults with partial seizures with or without secondary generalisation. Treatment of Generalised Anxiety Disorder (GAD) in adults. **Dosage:** *Adults*: 150 to 600mg per day, given in either two or three divided doses taken orally. Treatment may be initiated at a dose of 150mg per day and, based on individual patient response and tolerability, may be increased to 300mg per day after an interval of 3-7 days (for neuropathic pain) or 7 days (for epilepsy or GAD), the dose may be increased to 450mg per day after an additional 7 day interval (for GAD), and to a maximum dose of 600mg per day after a further 7-day interval. Treatment should be discontinued gradually over a minimum of one week. *Renal impairment/ Haemodialysis*: dosage adjustment necessary, see SmPC. *Hepatic impairment*: No dosage adjustment required. *Elderly*: Dosage adjustment required if impaired renal function. *Children and adolescents*: Not recommended. **Contra-indications:** Hypersensitivity to active substance or excipients. **Warnings and precautions:** There have been reports of hypersensitivity reactions, including cases of angioedema. Pregabalin should be discontinued immediately if symptoms of angioedema, such as facial, perioral, or upper airway swelling occur. Patients with galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take Lyrica. Some diabetic patients who gain weight may require adjustment to hypoglycaemic medication. Occurrence of dizziness and somnolence could increase accidental injury (fall) in elderly patients. There have also been post marketing reports of loss of consciousness, confusion and mental impairment. Cases of renal failure have been reported and discontinuation of pregabalin did show reversibility of this adverse effect. In controlled studies, a higher proportion of patients treated with pregabalin reported blurred vision than did patients treated with placebo which resolved in a majority of cases with continued dosing. In the clinical studies where ophthalmologic testing was conducted, the incidence of visual acuity reduction and visual field changes was greater in pregabalin-treated patients than in placebo-treated patients, the incidence of fundoscopic changes was greater in placebo-treated patients. In the postmarketing experience, visual adverse reactions have also been reported, most of which refer to transient vision loss, visual blurring or other changes of visual acuity. Discontinuation of pregabalin may result in resolution or improvement of these visual symptoms. Suicidal ideation and behaviour have been reported in patients treated with anti-epileptic agents. A meta-analysis of randomised placebo controlled trials of anti-epileptic drugs has also shown a small increased risk of suicidal ideation and behaviour. The data does not exclude the possibility of an increased risk for pregabalin. Patients should be monitored for signs of suicidal ideation and behaviours and appropriate treatment should be considered. Patients (and caregivers of patients) should be advised to seek medical advice should signs of suicidal ideation or behaviour emerge. Insufficient data for withdrawal of concomitant antiepileptic medication, once seizure control with adjunctive Lyrica has been reached, in order to reach monotherapy with Lyrica. After discontinuation of short and long-term treatment withdrawal symptoms have been observed in some patients, insomnia, headache, nausea, diarrhoea, flu syndrome, nervousness, depression, pain, sweating and dizziness. The patient should be informed about this at the start of the treatment. Concerning discontinuation of long-term treatment there are no data of the incidence and severity of withdrawal symptoms in relation to duration of use and dosage of pregabalin (see side effects). There have been post-marketing reports of congestive heart failure in some patients receiving pregabalin. These were mostly elderly, cardiovascular compromised patients who received treatment for a neuropathic indication. Pregabalin should be used with caution in these patients. Discontinuation of pregabalin may resolve the reaction. **Ability to drive and use machines:** May affect ability to drive or operate machinery. **Interactions:** Pregabalin appears to be additive in the impairment of cognitive and gross motor function caused by oxycodone and may potentiate the effects of ethanol and lorazepam. In the postmarketing experience, there are reports of respiratory failure and coma in patients taking pregabalin and other CNS depressant medications. **Pregnancy and lactation:** Lyrica should not be used during pregnancy unless benefit outweighs risk. Effective contraception must be used in women of childbearing potential. Breast-feeding is not recommended during treatment with Lyrica. **Side effects:** Adverse reactions during clinical trials were usually mild to moderate. Most commonly (>1/10) reported side effects in placebo-controlled, double-blind studies were somnolence and dizziness. Commonly (>1/100, <1/10) reported side effects were appetite increased, euphoric mood, confusion, libido decreased, irritability, ataxia, disturbance in attention, coordination abnormal, memory impairment, tremor, dysarthria, paraesthesia, vision blurred, diplopia, vertigo, dry mouth, constipation, vomiting, flatulence, erectile dysfunction, fatigue, oedema peripheral, feeling drunk, oedema, gait abnormal and weight increased. See SmPC for less commonly reported side effects. After discontinuation of short and long-term treatment withdrawal symptoms have been observed in some patients, insomnia, headache, nausea, diarrhoea, flu syndrome, nervousness, depression, pain, sweating and dizziness. Concerning discontinuation of long-term treatment there are no data of the incidence and severity of withdrawal symptoms in relation to duration of use and dosage of pregabalin (see warnings and precautions). In the post-marketing experience, the most commonly reported adverse events observed when pregabalin was taken in overdose included somnolence, confusional state, agitation, and restlessness. **Legal category:** POM. **Date of revision:** December 2008. **Package quantities, marketing authorisation numbers and basic NHS price:** Lyrica 25mg, EU/1/04/279/003, 56 caps £64.40, EU/1/04/279/004, 84 caps £96.60, Lyrica 50mg, EU/1/04/279/009, 84 caps £96.60, Lyrica 75mg, EU/1/04/279/012, 56 caps £64.40, Lyrica 100mg, EU/1/04/279/015, 84 caps £96.60; Lyrica 150mg, EU/1/04/279/018, 56 caps £64.40, Lyrica 200mg, EU/1/04/279/021, 84 caps £96.60, Lyrica 300mg, EU/1/04/279/024, 56 caps £64.40, Lyrica 225mg, EU/1/04/279/034, 56 caps £64.40. **Marketing Authorisation Holder:** Pfizer Limited, Ramsgate Road, Sandwich, Kent, CT13 9NJ, UK. Lyrica is a registered trade mark. **Further information is available on request from:** Medical Information Department, Pfizer Limited, Walton Oaks, Dorking Road, Walton-on-the-Hill, Surrey KT20 7NS.

REFERENCES: 1. van Seventer R *et al. Curr Med Res Opin* 2006;22:375–384 **2.** Siddall PJ *et al. Neurology* 2006;67:1792–1800 **3.** Portenoy R *et al.* Pregabalin for painful diabetic peripheral neuropathy and postherpetic neuralgia: onset and duration of analgesia in combined analyses of clinical studies. Poster presented at the 25th Annual Scientific meeting of the American Pain Society, San Antonio, Texas, 3–6 May 2006. **4.** Freynhagen R *et al. Pain* 2005;115:254–263

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Pfizer Medical Information on 01304 616161

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LYN537o March 2009

MPs briefed on vascular checks and flu jabs

Conservative MPs get behind local pharmacy services

The Tories had a high profile in C+D's Building Bridges campaign as well as the polls last week, as two Conservative MPs visited their local community pharmacies.

North East Hertfordshire MP and former shadow health minister Oliver Heald (pictured top right) got behind the till of Manor Pharmacy in Letchworth with superintendent pharmacist and owner Graham Phillips and staff.

The pair discussed how Manor Pharmacy could support local GP surgeries by providing vascular checks and MURs. Mr Phillips said: "I explained to him how what we would be doing is not duplicating services that doctors already provide, but supporting those services."

And in Kent, Sevenoaks MP Michael Fallon (pictured bottom right) officially launched Sainsbury's Pharmacy's seasonal flu vaccination programme. He had supported the programme "to promote choice" in healthcare providers, Mr Fallon told C+D. "What's really important is that people have a choice and that's what I'm in favour of."

The Sevenoaks Sainsbury's Pharmacy had already carried out around 100 vaccinations in the past three weeks, pharmacist manager Karina Hui (pictured right with Mr Fallon) said. "I love doing the vaccinations – it's a fantastic thing for the public and you feel great after doing it." **JR/JC**

North East Hertfordshire MP Oliver Heald (top) got behind the till of Manor Pharmacy in Letchworth with superintendent pharmacist and owner Graham Phillips, while Sevenoaks MP Michael Fallon (above) launched Sainsbury's Pharmacy's flu vaccination programme

Pharmacist struck off for campaign against healthcare professionals

A woman pharmacist who made allegations against doctors and breached court rulings preventing harassment has been struck off the RPSGB's register.

Neelu Chaudhari of Ilford targeted medics and other healthcare professionals after her niece died at the King George Hospital, Ilford, in 2000.

RPSGB disciplinary committee chairman John Burrow announced her removal after she was found guilty of allegations of misconduct, saying: "She caused serious mental suffering to fellow professionals."

On May 20, 2000, Ms Chaudhari's niece was born with "several medical complications" at the King George Hospital. An emergency protection order was obtained by the Barking, Havering and Redbridge Hospitals NHS Trust, but during an appeal by the family, the girl died.

Later, Ms Chaudhari "published material on websites, demonstrated on the Trust's hospital premises and distributed leaflets," an RPSGB disciplinary meeting heard.

An injunction was obtained preventing her from going to or obstructing the Trust's hospitals, but High Court proceedings heard she had breached those and she was given a permanent restraining order.

During a three-year period the Royal Pharmaceutical Society has been involved in bringing a disciplinary case against her involving costs of £70,000.

Ms Chaudhari has three months to appeal against the verdict. **UKL**

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Sources for No.1 claims ore IRI MAT 24.01.09 and IRI 12 WE 24.1.09

STOCK UP FOR THE COUGH SEASON WITH THE UK'S NO.1 FASTEST GROWING MAJOR COUGH BRAND

Alliance Boots has a global dream

One hundred and sixty years after Boots was founded, Ornella Barra, CEO of the company's wholesale division, reveals Boots' ambition to create a global brand to **Chris Chapman**

Imagine you're visiting a city, anywhere in the world, for the first time. You need to pop in to a local pharmacy. Alliance Boots chief Ornella Barra wants you to be able to know what services it offers before you even open the door.

"For customers, it's easy to travel across the world," she says. "I want to see the same services and layout [of pharmacies] in different countries."

The vehicles for delivering this global flavour will be the Alphega Pharmacy virtual chain and wholesaler Alliance Healthcare, she says. Alphega acts as an umbrella group – providing head office support and training for independents from Lazio to Lanarkshire. Ms Barra heads up the initiative in her role at the helm of Alliance Boots pharmaceutical wholesale division, which has a presence in 16 countries.

Alphega is a key project for the company, Ms Barra explains. The concept offers independent pharmacies the benefits of Alliance Boots' international presence, such as exclusive retail brands and increased buying power, she adds. But in the UK, pharmacists have been slow to buy in to the global dream. Alphega, with 250 members, is smaller than rivals such as Numark and Avicenna, which both boast more than 1,000 representatives. But Ms Barra is not disheartened.

"Starting two years ago in the UK, Alphega already has 250 pharmacies. It's a good number… but it's not enough for me."

But Alphega's growth is just one part of the Alliance Boots masterplan.

Ms Barra clocks up more air miles in a month than most people do in a lifetime with her remit that not only covers Europe but also emerging markets such as Brazil and China. She plans to spread parent company Alliance Boots' reach to all corners of the globe.

"The project and the mission for Alliance Boots is to begin a global company. And a global world label. I want to consolidate the market, but also increase in other continents – Asia especially, but also Latin America."

And Ms Barra believes success on a global scale will deliver direct benefits to pharmacies in the UK.

Globalisation in the pharmaceutical industry will bring manufacturers much closer to the pharmacies they supply, she states. This will mean services from manufacturers tailored to the individual needs of pharmacists, the AB chief predicts. Ms Barra says: "With globalisation, relationships with manufacturers will change completely."

A key part of being a global player is to have one corporate identity. Starting two years ago, the company began the process of rebranding all its wholesale businesses, which saw UK wholesale arm UniChem rebranded as Alliance Healthcare. Ms Barra says that having the same name for the company helps internally, but also benefits stockholders and improves relationships with global partners such as big pharma. Ms Barra says that as a global company, Alliance Boots is able to monitor, anticipate and act on international trends.

It explains why the company is investing overseas. Ms Barra says that while European economic growth is, on average, around 3 to 4 per cent, China's economy is growing in double digits and is set to outpace the US in terms of production. If Alliance Boots wants to be a global giant, it needs to capture a share of the China market.

The main challenge is scale. Alliance Boots is already in China, working in a 50/50 partnership with Guangzhou Pharmaceutical. But despite the duo being the fourth largest wholesaler in the country, their market share is only around 3 per cent. Ms Barra says that while China is a big apple to take a bite from, time invested now will reap rewards later.

"The wholesale market is more fragmented, because the dimension of the country is very big. I think it's necessary to spend time, but it represents a good opportunity for us."

Ms Barra's message is clear: whether you are part of Alliance Boots' pharmacy team, supported by its wholesaling or generics arms, or a member of its virtual chain, globalisation is a real benefit. Alliance Boots aims to develop a pharmacy empire on which the sun never sets.

"The project and the mission for Alliance Boots is to begin a global company"

ORNELLA BARRA

The Alliance Boots global strategy

- Develop a global brand identity to build relationships with global partners
- Create a virtual chain of pharmacies, so that a pharmacy in Barcelona will have the same layout and list of services as one in Moscow
- Be flexible enough to adapt to the culture of each country and change the business model accordingly
- Continue to develop own brands, notably Boots laboratory in continental Europe
- Continue to develop in emerging markets, such as the partnership with Guangzhou Pharmaceutical in China

TRANSVASIN HELPING YOUR CUSTOMERS FEEL AMAZIN'

Whether it's playing with the kids, shopping or gardening, **Transvasin Heat Rub** provides warming relief from aches and pains, so your customers can carry on doing the things that make them feel amazin'.

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PACK SIZE	RRP
Transvasin 40g	£2.10
Transvasin 80g	£3.81

Contains (w/w)
Ethyl Nicotinate, Hexyl Nicotinate, Tetrahydrofurfuryl Salicylate

Presentation: Cream containing Hexyl Nicotinate 2% w/w, Ethyl Nicotinate 2% w/w and Tetrahydrofurfuryl Salicylate 14% w/w. **Indications:** For the relief of rheumatic and muscular pain and the symptoms of sprains and strains. **Contradictions:** sensitivity to any ingredient. **Warnings:** Transvasin cream should not be applied to broken or sensitive skin, for example around the eyes or scrotal skin. Avoid use on mucous membranes. Discontinue use if rash develops. Not for use with occlusive dressings. Avoid exposing treated areas to excessive sunlight. **Pregnancy:** use with caution. **Side Effects:** temporary local sensitization. **Pack size:** 40g & 80g. **Further information available from license holder:** Thornton & Ross Ltd, Linthwaite, Huddersfield, HD7 5QH. **Classification:** GSL. **Product License:** PL 00240/0062. **Date of preparation:** August 2008

Accumulate savings

The sums are simple.
The more you spend the more you save. And the discounts start from the very first pound.
That's how to buy generics.

Eye and skincare range comes to UK pharmacy

Butterflies Healthcare is introducing a natural French eye and skincare product range into UK pharmacies.

NATorigin is made by Contapharm Laboratories, which says the products contain a minimum of 97 per cent naturally-sourced ingredients.

The range is formulated to be suitable for consumers with known allergies and people who may be intolerant to unknown irritants often found in eye and skincare products.

The range comprises five products: hand and nail cream, eye make-up remover lotion, eye make-up emulsion and a pencil eyeliner and mascara, which both come in four colours.

The products are approved by the Vegetarian Society and come in recyclable packaging.

An eye-catching display unit is available for use on counter tops, gondola ends, open shelving or in a flexible modular display system.

Retail prices range from £6.75 for pencil eyeliner to £12.00 for mascara.
Butterflies Healthcare
Tel: 0845 838 6704
www.butterflies-healthcare.co.uk

Actavis has generic topiramate

Actavis has launched a generic version of topiramate following a recent patent expiry.

The company has introduced topiramate in 25mg, 50mg, 100mg and 200mg film-coated tablets in packs of 60.

Topiramate is indicated in adults for the prophylaxis of migraine headache and as monotherapy in adults and children aged six years and above with newly diagnosed epilepsy who have generalised tonic-clonic seizures or partial seizures.

NHS prices: £12.79 25mg/60, £21.01 50mg/60, £37.64 100mg/60, £73.10 200mg/60
Pip codes: See C+D Monthly Price List or www.cddata.co.uk
Actavis UK
Tel: 01271 311200

New name for probiotics range

Wren Laboratories has rebranded its DTECTA probiotics range as OptiBac Probiotics. The range is designed to aid good health and digestion, and to boost natural immunity.

The range comprises seven supplements formulated with different combinations of probiotic strains to target specific conditions and improve the sense of wellbeing.

Products include Immunox for daily immunity, AntiBloat for a flat stomach, A'Biotica for those on antibiotics, DiarSafe for bowel calm and ProbioStart for children's health.

The products come in a capsule and sachet form, which can be mixed with water and taken daily.

Prices: From £2.99/8 to £24.99/80 DiarSafe capsules
Wren Laboratories
Tel: 01264 339770
www.optibacprobiotics.co.uk

Ransom renames jointcare brand

William Ransom is to relaunch its Health Perception brand as the Ransom Jointflex range.

New branding and packaging for the current Health Perception products, which include GlucOsamine and GlucOsamax, will be phased in over six months.

The new packs will feature a system that divides products into three categories (Daily, Extra and Max) to indicate product strength and individual jointcare need.

The first new product is Jointflex Extra, designed to be an everyday jointcare supplement for active people. It contains glucosamine sulphate 500mg with high potency omega-3, cod liver oil, turmeric and ginger.

The launch will be supported by a campaign in daily newspapers and weekend supplements from this month, plus online activity and PoS material.

Price and Pip code:
Jointflex Extra £12.71/30 tablets + 30 capsules, 348-0969
William Ransom
Tel: 01462 437615

Market focus

- Glucosamine-based supplements are growing by 13 per cent in value and 15 per cent in volume year on year (IRI January 2009).
- There is a growing trend for 'blend' jointcare supplements.
- Sixty seven per cent of people complain of 'aching joints' that affect them directly or a person in their household (Ransom survey December 2008).

TV advertising debut for Kaloba and Karma

Schwabe Pharma's licensed herbal medicines Kaloba and Karma will be on TV for the first time this winter.

The company is investing £500,000 in a national TV campaign for Kaloba, which relieves symptoms of upper respiratory tract infections, and Karma, which is used to relieve the symptoms of low mood.

Both products will be on ITV1 from October 26 until December 14. They are available from the Miles Group.

Schwabe Pharma UK
Tel: 01628 401980

Retail talk

Are you selling more supplements to help boost the body's immune system?

Yes 46%

No 54%

Off the shelf view:
A split response this week with just under half of respondents reporting an increase in sales. Chances are that concern about swine flu is adding to the usual seasonal demand.

This week's question:
Are parents confused about the new guidelines for children's cough and cold medicines? Vote at **www.chemistanddruggist.co.uk/prodnews**

Check out what's on TV

www.chemistanddruggist.co.uk/prodnews

The campaign for EllaOne for pharmacy

> EHC FROM PHARMACY IS A CAST IRON, UNQUALIFIED SUCCESS STORY WE SHOULD BE SHOUTING ABOUT

I would like to nominate a new POM medicine for fast tracking to pharmacy-only status. EllaOne (ulipristal acetate) is a new oral EHC that is licensed for use up to five days after unprotected intercourse (C+D, October 17, p14).

It prevents more than 98 per cent of pregnancies if taken within five days of sex. In contrast, levonorgestrel is only 95 per cent effective if taken within 24 hours, falling to 58 per cent after 72 hours. This is a huge improvement in contraception. But it will only be available to those women who can access their GP within five days.

Making EHC available over the counter has been one of pharmacy's biggest success stories of the past 10 years. Around half of women who need EHC now obtain it from a pharmacy, with no increase in the overall use of EHC and no fall in the use of regular methods of contraception. That is a cast iron, unqualified success story that we should be shouting about and building upon.

Undoubtedly, the OTC switch of Clamelle and, hopefully, the forthcoming switch of a range of oral contraceptives, are building on this success. We are now increasingly recognised as an important source of contraception and sexual health services.

The success of Levonelle has largely been down to the fact that we are offering exactly the same product as GPs, with the same level of safeguard and advice, but with much improved access. Our case becomes much weaker if patients are able to obtain a superior product from their GP. And because this product is more effective for longer, waiting another couple of days for a GP appointment becomes less of an issue.

I now feel duty bound when advising patients, particularly those consulting close to the 72 hour limit, that there is a more effective product available from their GP. I can only give them the facts and allow them to make up their own mind.

EllaOne's SPC doesn't reveal any drastic side effects that would limit its use to prescription-only, but it must demonstrate some safety-in-use data before a switch is considered. If that relative safety is demonstrated, and we are to continue to maintain our important role in sexual health, this is a product that we must be able to supply.

If Levonelle is superseded by ellaOne I would like to extend my warmest thanks to Schering for its enormous contribution to developing our role. I only hope that if ellaOne is ever switched, the manufacturer responsible provides pharmacists with the same level of support that has been key to Levonelle's success.

Commissioning: are we nearly there yet?

We support the government's vision for pharmacy. It is reassuring to see that the developments PSNC has called for have been acknowledged. But it's also difficult to disagree with the Conservative spokesman who last week called community pharmacy the country's "most under-utilised national resource in the delivery of services to NHS patients".

To contractors, whose skills too often go unused to the detriment of their local communities, nothing is more frustrating than unrealised potential. Pharmacists' strong links with their patients make them ideally placed to support those with long-term conditions.

A new 'First Prescription Service' will mean patients receive tailored support when they start a new medicine. A better targeted MUR will reduce waste, saving GPs time and PCTs money. Pharmacies are the most cost-effective providers of minor ailments services and we are discussing with NHS Employers how this service could be provided nationally.

So why does such expansive potential, in many cases, remain just that? As we told the Health Select Committee last month, PCT commissioning of enhanced pharmacy services is regrettably patchy. While there are strong examples of best practice in commissioning, the same problems are cropping up across the country: inadequate communication between PCTs and LPCs; inconsistent and unclear responsibility for commissioning pharmacy services; a failure to adequately remunerate contractors – I could go on.

C+D revealed last month that only a third of LPCs rate their PCTs 'good' or 'excellent' at commissioning pharmacy services. It's encouraging to know one third are good. It is completely unacceptable to hear that two thirds are letting patients down by failing to commission undeniably valuable services.

We cannot sit on our hands and wait for PCT commissioning to improve. Patients should no longer be deprived of access to services with indisputable benefit to all communities. Should PCTs not be centrally directed to commission these services?

The coming months herald our greatest opportunity to secure the white paper's vision. We're negotiating with NHS Employers on new national services I have described above and we will jointly present recommendations to the DH. We will strive to ensure government does its part to improve and direct commissioning. And we will continue to support contractors in communicating the value of new services to PCTs. But contractors and LPCs also have a vital role to play; despite the frustrations involved, they have a responsibility to work with even the most ineffective of commissioning organisations.

Community pharmacy must not let the moment pass. If we miss this opportunity to carve a new role for pharmacy, it may not come again. Nothing is more frustrating than unrealised potential. So let us work together to realise ours.

Sue Sharpe is chief executive of PSNC

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24.10.09

Features

Cymex

The simple answer to cold sores

There are three simple reasons why Cymex should be recommended for cold sores

1. Cymex is the word on everyone's lips as £750,000 is being invested in the brand with an intensive consumer advertising and PR campaign in women's magazines

2. Cymex is a brand on the move, with an impressive 52% growth in share of sales in the past two years[1]

3. Cymex offers a complete cold sore package, giving sufferers the choice between a soothing relief option from Cymex Cream or an aciclovir treatment option from Cymex Ultra

1 IRI £ data, August 2009

WIN

A design classic Alessi kettle

From the famous Italian design house, this stainless steel Alessi kettle in ivory will add a touch of class to your staffroom.

The 2.4kW cordless kettle has a 1.5 litre capacity so all pharmacy staff can enjoy a well-deserved tea break.

Simply answer the questions on the tear-off coupon overleaf, put it in the post and you could be a winner!

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You can't kiss with cold sores, but you can K.I.S.S with Cymex

Keep It Simple for Sufferers with Cymex

The Cymex range offers cold sore sufferers two options:

Cymex Cream

Triple action formula to relieve painful cold sores and dry cracked lips

- Soothes the tell-tale tingle of cold sore
- Relieves dry cracked lips
- Controls infection

Cymex Ultra

Anti-viral formulation that can cut the duration and pain of a cold sore episode

- Can stop the spread of the herpes virus that causes cold sores
- For best effect apply at the first sign of an attack – at the tingle stage and before the blisters appear – and continue use for five days

People who come into your pharmacy seeking a cold sore treatment are looking for:

Reassurance:
Most episodes of cold sores are mild and the blisters should heal without scarring.

Advice:
Don't spread it around! Avoid kissing and be careful when handling your contact lenses. Try not to touch the infected area – but if you do, wash your hands thoroughly afterwards. Smooth Cymex onto the affected area. The tingling sensation that signals a cold sore attack will last between 6-48 hours.[1] Pain is usually most severe in the 24 hours after the blisters appear.[1] Crusting of the blister usually occurs with 48 hours.[1]

Referral:
If the initial cold sore spreads, new cold sores develop after the initial attack, there is persistent fever or no significant improvement after 7 days, refer the customer to their GP.

1 www.cks.nhs.uk/herpes_simplex_oral/view_whole_topic

For further information visit www.cymex.co.uk

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Cymex Cream Product Information:
Presentation: White cream containing 1.0% w/w Urea BP, 0.5% w/w Cetrimide BP, 9.0% w/w Dimeticone 350 BPC and 0.1% w/w Chlorocresol BP **Indications:** Relief of cold sores and cracked lips **Dosage:** Apply sparingly every hour **Contra-indications:** None known Warnings and precautions: For external use only. If symptoms persist consult a doctor **Interactions:** None known **Pregnancy and lactation:** Can be used during pregnancy and lactation **Undesirable effects:** None known **Legal category:** GSL MA number 20306/0098 **MA Holder:** Actavis Group PTC ehf, Reykjavikurvegi 76-78, 220 Hafnarfjordur Iceland **Pack size:** 5g tube (RRP £1.90 excl VAT) **Date of preparation:** October 2008

Cymex Ultra Product Information:
Name: Cymex Ultra Active ingredient Aciclovir 5% w/w Cream **Indication:** Treatment of herpes simplex virus infections of the lips and face **Dosage and Administration:** Treatment should be initiated as soon as possible after start of infection. A thin film of cream should be applied to the infected and immediately adjacent skin areas 5 times a day at 4 hourly intervals throughout the day. Treatment should be continued for 5 days, followed by a further 5 days treatment if healing has not occurred. **Contraindications:** Hypersensitivity to aciclovir or any other preparation ingredients **Warnings and precautions:** Consider oral dosing in severely immunocompromised. The cream must not be applied to the mucous membranes, as local irritation may occur. Avoid contact with the eye. Only recommended for use on cold sores on the lips and face. Cetyl alcohol may cause local skin reactions. Propylene glycol may cause skin irritation. Interactions: Probenicid. **Pregnancy and lactation:** Seek advice of doctor before use **Undesirable effects:** Occasionally reddening, dehydration and scaling of the treated skin. After application transient burning or stinging of the treated skin area may occur **Legal Category:** GSL **PL number:** 20395/0001 PL holder: Relonchem Limited, 27 Old Gloucester Street, London WC1 3XX **Pack size:** 2g tube (RRP £3.47 excl VAT) **Date prepared:** June 2008.
For further sales information contact Actavis (UK) Ltd, Whiddon Valley, Barnstaple, North Devon, EX32 8NS

Rules:
1. The prize draw is open to pharmacists and pharmacy staff employed full or part time in a UK pharmacy at the closing date.
2. Employees of Actavis UK, its trading divisions and their immediate families are not eligible to enter.
3. Entries are restricted to one per person.
4. The winner of the prize will be the sender of the coupon that is drawn first on the closing date with the qualifying questions correctly answered.
5. No purchase is required to enter.
6. The prize offered will be as stated. No alternatives or cash prizes will be offered.
7. The closing date for entries to the prize draw is November 23, 2009.
8. Proof of postage is not regarded as proof of receipt.
9. The name of the winner will be available on application to Lexis PR, 8 Bolsover Street, London W1W 6AB after the closing date.

To be entered into the prize draw to win an Alessi Kettle simply:

- **answer the questions below correctly**
- **complete the name and address panel**
- **tear off the coupon, fold where indicated and tape along the edge**
- **stick a stamp on the front and put it in the post.**

1. When it comes to Cymex, K.I.S.S. is an acronym which stands for:

- ❑ Keep in-store to sell
- ❑ Kick-in sales strategy
- ❑ Keep it simple for sufferers

2. Sales of Cymex have risen by how much in the past two years?

- ❑ Sterling sales have gone up by 52%
- ❑ Pack sales have gone up by 25%
- ❑ Share of sales has increased by 52%

3. Cymex Cream is available in a pack size of:

- ❑ 2g tube RRP: £2.15
- ❑ 3g tube RRP: £2.85
- ❑ 5g tube RRP: £2.19

4. Cymex Ultra contains:

- ❑ 1% aciclovir
- ❑ 5% aciclovir
- ❑ 9% aciclovir

FROM:

Name: _____

Pharmacy: _____

Address: _____

_____

_____

_____

_____

_____

Postcode: _____

Telephone number: _____

Actavis Competition
Pharmacy Projects
CMP Medica
Riverbank House
Angel Lane
Tonbridge
Kent
TN9 1SE

Affix stamp here

Fold here

Tape edges together

Update

Your weekly CPD revision guide

Drug-induced problems of the nervous system

Part 2: drugs that act within the central nervous system

Professor Janet Krska

Should I take this new antidepressant that Dr Jones has prescribed for me? What will it do to me?

How should pharmacists respond to these questions? Our tendency is to assume that benefits from taking medicines will outweigh any adverse effects. But patients may not see it that way, and this view is often reinforced by their experiences, particularly with psychotropic drugs. The mental health charity Mind estimates 1.9 million people get no benefit from medication at all, and there are numerous websites, such as http://experience.patient.co.uk and now a book[1] devoted to patients' adverse experiences of medicines. These make disturbing reading for pharmacists and others trying to encourage compliance.

Patients are encouraged to seek information about side effects. Indeed the NHS Choices website (http://nhs.medguides.medicines.org.uk/nhs/default.aspx) provides extensive information and, in many cases, links readers directly to SPCs. Yet often the patient's perspective is ignored by health professionals,[2] and all health professionals, including pharmacists, would benefit from greater understanding of what taking medicines is like from the patient perspective.

Drugs designed to act on the central nervous system are the group most likely to cause or worsen pre-existing psychiatric or neurological problems. Hence antipsychotics, antidepressants, hypnotics, anxiolytics, anti-epileptics, anti-Parkinson's drugs, antidementia drugs, analgesics and drugs for addiction can all cause a wide variety of symptoms involving mood, behaviour, consciousness, sensation and movement (see summary in Tables 1 and 2 in the full version of this article, online at www.chemistanddruggist.co.uk/update). It is also common for patients to receive more than one centrally-acting drug simultaneously, risking additive side effects. Furthermore, withdrawal or even just missing doses of many centrally-acting drugs can precipitate psychiatric or neurological symptoms.

Mood changes

Some drugs used to treat depressive symptoms in patients with bipolar disorder have the propensity to shift mood from low to high, precipitating a full-blown manic episode or hypomania. This usually occurs on starting the drug or increasing dosage and can sometimes be managed by dose reduction, but requires psychiatric assessment.

Levodopa has been reported to cause depressive or euphoric symptoms, but as patients with Parkinson's disease can experience mood changes because of their condition, identifying ADRs requires specialist investigation. Many anti-epileptic drugs are associated with changes in mood and behaviour, including euphoria, mania, depression, labile mood or emotions, anxiety and disinhibition. Suicidal ideation has been reported with a number of anti-epileptic drugs and depression has been reported after stopping pregabalin. Patients taking anti-epileptics should be monitored for suicidal ideation and behaviour.

Opioids obviously cause changes in mood, usually euphoria, which is important in their role as analgesics and contributes to dependence. Dysphoria (low mood) is perhaps a lesser known problem, and is possibly due to effects on kappa receptors. It is also a feature of opioid withdrawal.

Somewhat paradoxically the CNS stimulants modafinil and atomoxetine have been reported to cause depression, as has sibutramine. The latter has been associated with suicidal ideation and suicide, so it is important to withdraw the drug if symptoms of depression occur. Hypnotics and anxiolytics can sometimes cause paradoxical increases in excitement, anxiety and aggressive behaviour. These are most common when high doses are used.

Depression can occur with galantamine and memantine, potentially leading to suicidal thoughts, although generally drug treatment improves depressed mood in patients with dementia. All antidementia drugs can cause psychotic symptoms.

Some triptans have been reported to cause depressed or elevated mood, while both pizotifen and clonidine, which are used in migraine prophylaxis, are well known to cause depression.

Psychiatric reactions, notably depression and suicidal thoughts, are the most commonly reported problem with varenicline. While depression can arise through stopping smoking, the drug causes symptoms independently of this. Bupropion, although used outside the UK as an antidepressant, can also cause depression, anxiety and hallucinations. Disulfiram can cause depression, mania or psychosis, though rarely.

60-second summary

Drugs acting on the CNS may cause or worsen psychiatric or neurological problems.

What is it important for pharmacists to know?

This article (Module 1506) can help you to achieve the following CPD competencies: G1a, G1b, G1d, G1e, G1b, E1d, C1

See http://tinyurl.com/68ox7b

Hallucinations

Hallucinations are experienced with a wide range of centrally-acting drugs, including opioids, drugs used in parkinsonism, most anti-epileptics, antidepressants and even some antipsychotics, although more frequently in patients with a previous psychiatric history. Zopiclone and zaleplon have also been reported to cause hallucinations. Levodopa can cause psychosis requiring withdrawal.

Confusion is a common side effect of drugs with antimuscarinic actions, including those used in parkinsonism, older antidepressants and antipsychotics, particularly in the elderly. Memory or other cognitive impairment, irritability, agitation and aggression can all occur with anti-epileptic drugs. Memory can be impaired by hypnotics and anxiolytics, which affect both acquisition of new information and cause 'episodic' memory loss, although long-term memory is not affected.

Sleep disturbances

There are very few centrally acting drugs that do not potentially affect sleep. Many drugs cause insomnia, including some antipsychotics, antidepressants (notably SSRIs), anti-Parkinson's drugs and antidementia drugs. Some anti-epileptics, particularly newer drugs, can also cause insomnia, although drowsiness is more common with older drugs. Bupropion is well known to cause sleep disturbance and should not be taken at night. It has also been reported to cause abnormal dreams, as has modafinil.

Similarly there are many drugs that can cause excess drowsiness and sedation, again including antipsychotics, antidepressants (notably older drugs) and anti-Parkinson's drugs, as well as hypnotics and anxiolytics. Many dopaminergic drugs can cause sudden onset of unplanned sleep during everyday activities, so patients should be warned when these drugs are newly prescribed and should avoid driving.

Neuropathies and aesthesias

Phenytoin is known to cause peripheral neuropathy but, along with other anti-epileptic drugs, is now used to treat this condition. Abnormal sensations (paraesthesiae) have been reported with several anti-epileptic drugs including phenytoin, carbamazepine, gabapentin, pregabalin and topiramate. Pregabalin has also been reported to cause asthenia (muscle weakness). Muscular weakness is a common side effect of benzodiazepines and other hypnotics that act on central benzodiazepine receptors. Both paraesthesia and asthenia have been reported with bupropion. Muscle weakness can be a sign of toxicity with lithium, especially if accompanied by ataxia, tremor or hyper-reflexivity.

Paraesthesiae have also been reported with tramadol, rivastigmine and galantamine. Disulfiram causes a range of symptoms due to peripheral neuritis.

More serious neurological ADRs

Movement disorders due to dopaminergic effects in the extra-pyramidal system are a well-known problem with many antipsychotics, particularly older drugs, in the form of parkinsonism, akathisia and tardive dyskinesia. Some antidepressants can also cause these problems, though more rarely. Metoclopramide acts by dopaminergic blockade so can cause extrapyramidal symptoms. These are especially common in children and young adults; they occur shortly after starting the drug, but resolve on stopping. Restlessness is a common manifestation. An injectable antimuscarinic is required for severe acute dystonia or oculogyric crisis.

Seizures can be precipitated by drugs that reduce the seizure threshold, including many antipsychotics, antidepressants, antidementia drugs, buproprion and ondansetron. Antipsychotics have been shown to increase the risk of stroke in elderly patients with dementia and those with pre-existing risk factors for stroke.

Serotonin syndrome is due to excess serotonin caused by high doses or combinations of drugs affecting serotonergic systems and includes confusion, hallucinations, tremor, hyper-reflexivity and autonomic symptoms such as vomiting, changes in blood pressure and temperature regulation. It can have a rapid onset and can rarely be fatal, although most cases are mild and resolve on drug withdrawal.

Neuroleptic malignant syndrome is due to excess dopaminergic blockade and is caused by high doses of antipsychotics and other drugs that block dopamine receptors, or following abrupt withdrawal of levodopa. It occurs within one to two weeks of starting or increasing the dose of antipsychotics and, like serotonin syndrome, includes psychiatric and motor disturbances, especially muscular rigidity akin to parkinsonism, together with disruption of autonomic control. It too can be fatal and often requires emergency management.

Symptoms on drug withdrawal

It is important to be alert to the possibility that new symptoms may occur on stopping centrally-acting drugs. The SSRI withdrawal syndrome includes paraesthesia, anxiety and sleep disturbance. Abrupt withdrawal of tricyclic antidepressants can result in a variety of symptoms, including anxiety, nightmares and akathisia. Benzodiazepine withdrawal can lead to confusion, psychosis and seizures.

Withdrawal effects of antipsychotics can include neurological disorders – acute dystonia, akathisia or dyskinesia, or long term dyskinesia, akathisia and paraesthesia. Severe dysphoria and depressed mood are common symptoms of opioid withdrawal.

Patient reporting of ADRs

There is probably more reason to involve the patient in identifying psychiatric and neurological ADRs than with any other type of reaction, as they involve mood, thoughts and behaviour. Only patients know their feelings and thoughts and, although health professionals can observe behaviours and movements and assess mood, the patient's perceptions are extremely important.

Perhaps for this reason, there are more self-rating scales for assessing side effects of centrally-acting drugs than for other drugs. For example, there are several for antipsychotics,[3-5] and others for antidepressants,[6] lithium[7] and anti-epileptic drugs.[8] Similar scales exist for some, including inhaled steroids, chemotherapy and H. pylori regimens.

Psychiatric and neurological side effects are those most commonly reported by patients through the Yellow Card scheme and psychotropic drugs are the drug group most commonly suspected as causative agents. The reason is not known, but could be due to health professionals' lack of understanding or appreciation of the importance of such effects to patients. Mind encouraged patients to report ADRs to them long before the MHRA scheme was established.[9]

While pharmacists may find it difficult to broach the subject of psychiatric problems, it is important not to ignore them. Because pharmacists often know their patients well and have provided continuity of care over many years, they may be well placed to pick up early symptoms of psychiatric problems. It is well known that patients with psychiatric conditions often have inadequate information about their medicines, so pharmacists can be useful in:

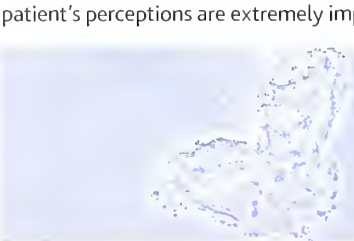
- explaining the potential for ADRs
- helping patients to understand literature
- helping patients to weigh up risks and benefits of treatment
- helping patients to identify suspected ADRs from other symptoms (use SCOOTA acronym)
- advising patients when to contact a doctor
- using simple questions to find out how patients are tolerating centrally-acting drugs during MURs or when starting new therapy
- encouraging patients to be open about psychiatric and neurological effects
- encouraging patients to report suspected ADRs to their doctor or via the Yellow Card scheme
- reporting suspected ADRs.

Janet Krska is professor of pharmacy practice, Liverpool John Moores University.

Download a CPD log sheet that helps you complete your CPD entry when you successfully complete the 5 Minute Test for this Update article online.

Update extra

Further information, including references and tables on the psychiatric and neurological adverse effects of centrally-acting drugs, can be found in the full version of this article at www.chemistanddruggist.co.uk/update



NEXT WEEK
The symptoms of bacterial vaginosis and when and how it is treated

Drug-induced problems of the nervous system

Reflect

Plan

Which drugs have been reported to cause hallucinations? What are serotonin syndrome symptoms? What psychiatric adverse effects could migraine treatments have?

This article outlines the centrally-acting drugs that can cause side effects affecting mood, behaviour, sleep and the nervous system. The author also discusses how pharmacists can help patients to identify and report these ADRs.

Read the first part of this Update article (C+D, October 17, 2009, p21-23, and www.chemistanddruggist.co.uk/update), together with other articles in this ADRs series.

Find out about anti-Parkinson's drugs and compulsive behaviour from the Parkinson's Disease Society at http://tinyurl.com/kqwz8n and http://tinyurl.com/ncvsyx.

Find out more about the adverse effects of benzodiazepines from the benzo.org.uk website at http://tinyurl.com/kr3lm2.

Learn more about serotonin syndrome and neuroleptic malignant syndrome on the Patient UK website at http://tinyurl.com/l6ugtp and http://tinyurl.com/murs9b.

Act

Think how you could use this information to help recognise CNS adverse effects when counselling patients and carrying out MURs.

Review

Are you now familiar with the centrally-acting drugs that may cause psychiatric ADRs and what effects they have? Could you confidently advise patients or carers?

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Practical Approach

A facial skin rash

Salma Hussain, formerly pre-registration trainee at the Update Pharmacy and currently working as a locum pharmacist, is working at a pharmacy in a country town. A man comes in and asks to speak to the pharmacist. When Salma goes out to him, he holds up a tube of betamethasone cream and says: "Have you anything better than this for the rash on my face?"

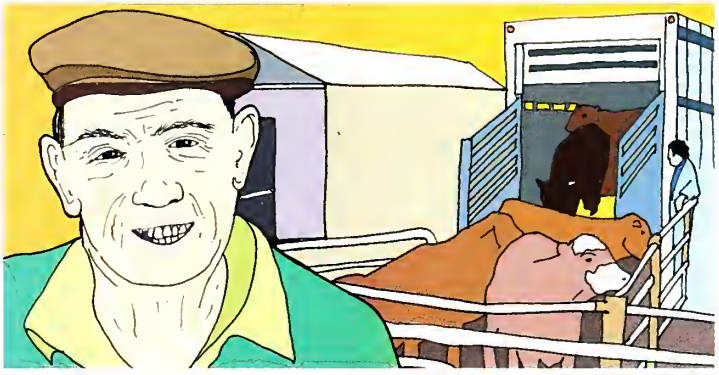
"Where did you get it?" she asks.

"From my GP's dispensary. I've been having it on and off for the last three years. It helps a bit, but I want something to get rid of the rash altogether."

"Did the doctor tell you what he thinks the cause is?" Salma asks.

"He says it's some sort of dermatitis, but he doesn't know what's causing it. He says it might disappear on its own one day. But I'm not convinced and it's damned itchy, so I thought I've got nothing to lose by asking at the chemists."

Salma asks to take a closer look at the rash. On inspection she sees that it is erythematous and scaly, with ring-like slightly raised lesions, on the man's cheeks, chin and neck. She says: "Can I ask what work you do?"



"I'm a livestock transport lorry driver."

After some thought Salma says: "I'll give you some cream that I think is worth a try. If it doesn't work, I think you should go back to your doctor and ask him for some tablets with the same active ingredient. And if they don't work, ask him to refer you to a dermatologist."

Questions

1. What did Salma think was the cause of the rash?
2. What was the treatment she recommended, and why did she suggest possible systemic therapy?
3. What other OTC treatments might Salma have recommended?

Answers

1. Tinea barbae (beard ringworm), a zoophilic dermatophyte infection of the bearded face, and therefore occurring almost exclusively in men. The condition used to be more common, but more effective disinfection of barbers' instruments and the advent of disposable razors have reduced its incidence. It is now mostly associated with contact with or exposure to animals, and infection can be transmitted by pets.

2. Terbinafine is the antifungal of choice for tinea barbae. Terbinafine cream is available without prescription and is worth trying, although topical treatment alone is usually insufficient to clear infection and it is used in conjunction with oral terbinafine. Terbinafine cream is not specifically licensed for treatment of tinea barbae, but there are no contraindications or serious side effects and Salma was prepared to accept the clinical responsibility for recommending it.

3. Azole antifungals: topical preparations of clotrimazole, econazole, ketoconazole and miconazole are all available without prescription. Oral itraconazole and griseofulvin (both prescription-only) have also been used successfully to treat tinea barbae.

This article can help with these CPD competencies: **G1a, G1c, G1d,G2o, C1a, C1f.**
See http://tinyurl.com/68ox7b

To see the full archive of Practical Approach articles go to **www.chemistanddruggist.co.uk/practicalapproach**

Meet the EPS pioneer

Pharmacist Jim Liptrot is at the cutting edge of IT development as his pharmacy was chosen to pilot release 2 of the electronic prescription service. **Zoe Smeaton** talks to the Leeds contractor to find out if it has been a success

Pharmacy bodies: what must the pilot prove?

NPA
"The assessment of EPS release 2 pilots must include operational functionality, ie the user and patient experience. A test merely of technical functionality will inevitably be incomplete and totally unacceptable to the NPA as a basis for rollout."

PSNC
"Initial implementation of the service is essential to ensure the impact of the service on the dispensing process can be fully evaluated. National deployment of EPS release 2 should only commence once the NHS and the pharmacy profession are confident that the service will not have an adverse impact on the safe and efficient supply of medicines to patients."

The view from NHS Connecting for Health

"The EPS release 2 in Calverley is of course assessing how it operates in a live pharmacy environment, as much as it is testing the technical effectiveness of the system. The work so far has allowed general practice staff, dispensary staff, NHS Prescription Services and CfH to use release 2.

"The sites in Leeds are finding that EPS release 2 works very well. Initial feedback from patients on the service has been positive. We are working on further pairings of surgeries and pharmacies in other initial implementer PCTs and the next pairing to go live will be announced shortly."

The electronic prescription service (EPS) certainly divides opinion. While some bemoan smart card problems and say download delays are making their job harder, other pharmacies say it will make life easier and they can't wait for the next phase.

Love it or hate it, though, EPS is gathering momentum. This summer, Liptrot Pharmacy in Calverley, near Leeds, was chosen to pilot release 2 of the service, which sees prescriptions being delivered electronically from the GP surgery to the pharmacy. For contractor Jim Liptrot, it has been quite an adventure.

The system is only being used for those patients who have opted to nominate the pharmacy to receive their prescriptions. Eligible patients who are already using repeat prescription services are being identified so the pharmacy is "not encroaching on anyone else's patients", Mr Liptrot says. He adds that explaining the service to them has not been a problem – they see little difference as the pharmacy was already collecting their prescriptions for them. "A lot of them thought the system was electronic anyway," he says.

At the moment the prescriptions are downloading from the surgery to the spine overnight and must be unlocked in the pharmacy in the morning when Mr Liptrot signs in with his smart card. The pharmacy then processes the script in the PMR system, with some fields being automatically populated. The pharmacy must note in the system when the item has been dispensed and collected.

Mr Liptrot says there is room for improvement. For example, he would like to see a function to enable counter staff to register when items have been collected, and he has been working with his system supplier Cegedim Rx to make the system as user friendly as possible.

Details of collected prescriptions are sent electronically for payment to be claimed, and Mr Liptrot sees this function as a major advantage of the system, saving time spent bundling scripts every month. However, he cautions that patients who are exempt from payment for reasons other than age still have to sign their scripts, so copies of these must be printed out, which is an added cost. In many cases advice slips for patients, listing their medicines, are also printed.

In the initial stages of the pilot Mr Liptrot has also been receiving paper copies of scripts so that he can compare them to the electronic versions. "That's taking up a lot of time, but it's so we can make sure the system is sending what we're intending it to send," he explains. "It's a good test." And despite the effort needed he says he is positive about the system and the benefits it will eventually bring pharmacies.

It's difficult to say when release 2 will be coming to a pharmacy near you. System suppliers say that with all the checks they are required to go through it is still a long way off, and indeed many estimate that they will not even begin pilots until next year. Connecting for Health (CfH), the agency leading the programme, previously estimated that it would take eight weeks from the date suppliers achieved technical accreditation (as Cegedim Rx has) for their systems to go through the pilots and achieve rollout approval. But the agency now states: "Once a supplier has achieved technical accreditation, the system is tested over a period of at least 45 days as part of the clinical assurance process."

However long it takes, though, now that the reality has been seen in one pharmacy, which seems to be enjoying benefits already, it's clear that EPS is moving forwards. CfH says more pilot sites will be announced shortly, and a second system supplier, Rx Systems, seems on the brink of joining Cegedim Rx in testing.

So for those who have not yet taken advice from pharmacy bodies to use release 1 to prepare themselves for the service, now might just be a good time to start listening.

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In ~6%, menstrual periods occurred >7 days early. In ~20% a delay of >7 days occurred, and in 5.1% the delay was >20 days. Contains lactose monohydrate; patients with galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should avoid. **Drug Interactions:** Ulipristal acetate is metabolized by CYP34A *in vitro*. No specific drug interaction studies have been performed *in vivo*. **Potential for other medicinal products to affect ulipristal acetate:** CYP34A inducers (e.g. rifampicin, phenytoin, phenobarbital, carbamazepine, ritonavir, St John's Wort/Hypericum perforatum) may reduce plasma concentrations of ulipristal acetate and decrease efficacy, even if stopped enzyme inducer within last 2-3 weeks. Concomitant use not recommended. 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Reference: 1. CHMP Assessment Report for ellaOne: Procedure No. EMEA/H/C/001027. Available at www.emea.europa.eu

Further information available from:

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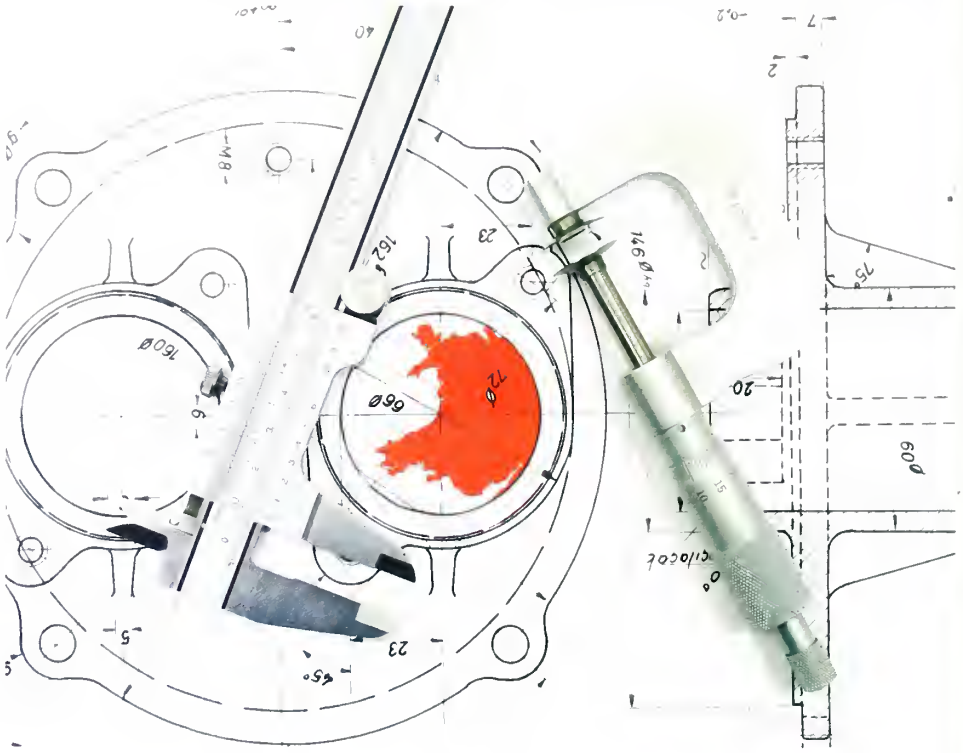

Planning the future

A Welsh strategy group has put forward its plan to revamp pharmacy services. **Zoe Smeaton** asks whether it's worth contractors buying in to the plans

Directed enhanced services, simplified pay and widespread repeat dispensing. The priorities identified by Wales's new strategic delivery group, while welcome, will hardly take pharmacists in the country by surprise. Many of the ideas have been mentioned in previous plans, both for pharmacy specifically and for healthcare in Wales.

So just how much of a difference is this new group, with its brief to ensure the speedy delivery of existing policy decisions and future opportunities for the sector, really going to make?

Quite a lot, is the resounding answer from its members and from contractors across Wales.

Perhaps the first positive sign is the fact that it has been set up by Wales's health minister, Edwina Hart, giving the group some political clout. As Cambrian Alliance chairman and contractor Mark Griffiths says: "We should commend the minister for setting up such a group of forward-thinking individuals... I think we can get something out of this."

The NHS is behind it too, with the chief executive already having written to local health boards (LHBs) directing them to support it, says group chair Chris Martin. And this will be key as some of the strategies, such as making enhanced payment claims more efficient, will require input from LHBs to become reality. Stephen Howarth, a contractor in Cardiff, believes progress will also be helped by the reduced number of health boards – this has been cut from 22 to seven – now in Wales. And Mr Martin says as some of the suggestions are likely to be worked into LHBs' operating frameworks for next year, they really will have to deliver. "That will mean it has to happen," he stresses.

The group also has the backing of other representative bodies as its members include people working for both the RPSGB and the NPA. The group's intention is to complement such organisations. For example if the strategic delivery group comes up with a recommendation, it would then still be for Community Pharmacy Wales to negotiate that with the government and for the Society to produce professional guidance.

So with the group apparently holding a number of aces, how is it now going to play its hand? The group has identified what it calls "quick wins", which it hopes can be brought into practice quickly.

Perhaps the most exciting of these is the establishment of four directed enhanced services, which Mr Martin believes could happen by the end of the year. Another area being tackled is repeat dispensing, where he explains GP champions – who have lots of patients using the service – will be encouraging LHBs and other GPs to embrace the service too.

> "THE WELSH GOVERNMENT ARE DOING THINGS DIFFERENTLY SO IT'S INEVITABLE THAT IT WILL BE ENSHRINED [IN A SEPARATE CONTRACT]"

Pilot services to reduce medicines wastage are a priority, as well as demonstrating how savings made by this can be reinvested back into community pharmacy. And the group also hopes to have introduced a standard claims procedure for enhanced services by the end of the year, something Mr Griffiths says will be popular given that payments had until now been a "bugbear" for the profession.

Also popular with many contractors will be plans to pilot the provision of vaccinations through pharmacy, which Mr Griffiths believes could lead to additional income streams. And investigations are also afoot to see whether Wales should have its own contract. Contractors told C+D they thought this would be an "inevitable" step and made sense as healthcare in the country was already devolved. As Mr Howarth says: "The Welsh Assembly Government are doing things in a different way so it's inevitable that it will be enshrined [in a separate contract]. I think it's as inevitable as night following day."

With such a flurry of activity, pharmacists on the English side of the border might well feel a pang of jealousy. As Shafique Govani, head of the Beta Buying Group, says: "It would be very nice to have a group like this in England; little progress has been made on things like directed enhanced services here." But with the DH seemingly keen to devolve more and more power to PCTs, it seems an unlikely hope.

However, there could be benefits all round if Wales makes headway that others can learn from. The group says far from duplicating efforts being made to develop services elsewhere, they hope to be able to work usefully alongside the other countries. Mr Martin says there will be a focus on looking at what is working elsewhere and finding different Welsh solutions where appropriate.

Whatever the impact on other countries though, for Wales at least the group looks set to bring change with its high level backing and achievable plans. Members and the pharmacy sector are all convinced the developments will be positive, and as group member Paul Gimson concludes: "Our initial strategy document isn't quite a white paper for Wales, but it is the start of building up a detailed strategy for pharmacy in Wales... this group is a catalyst for that."

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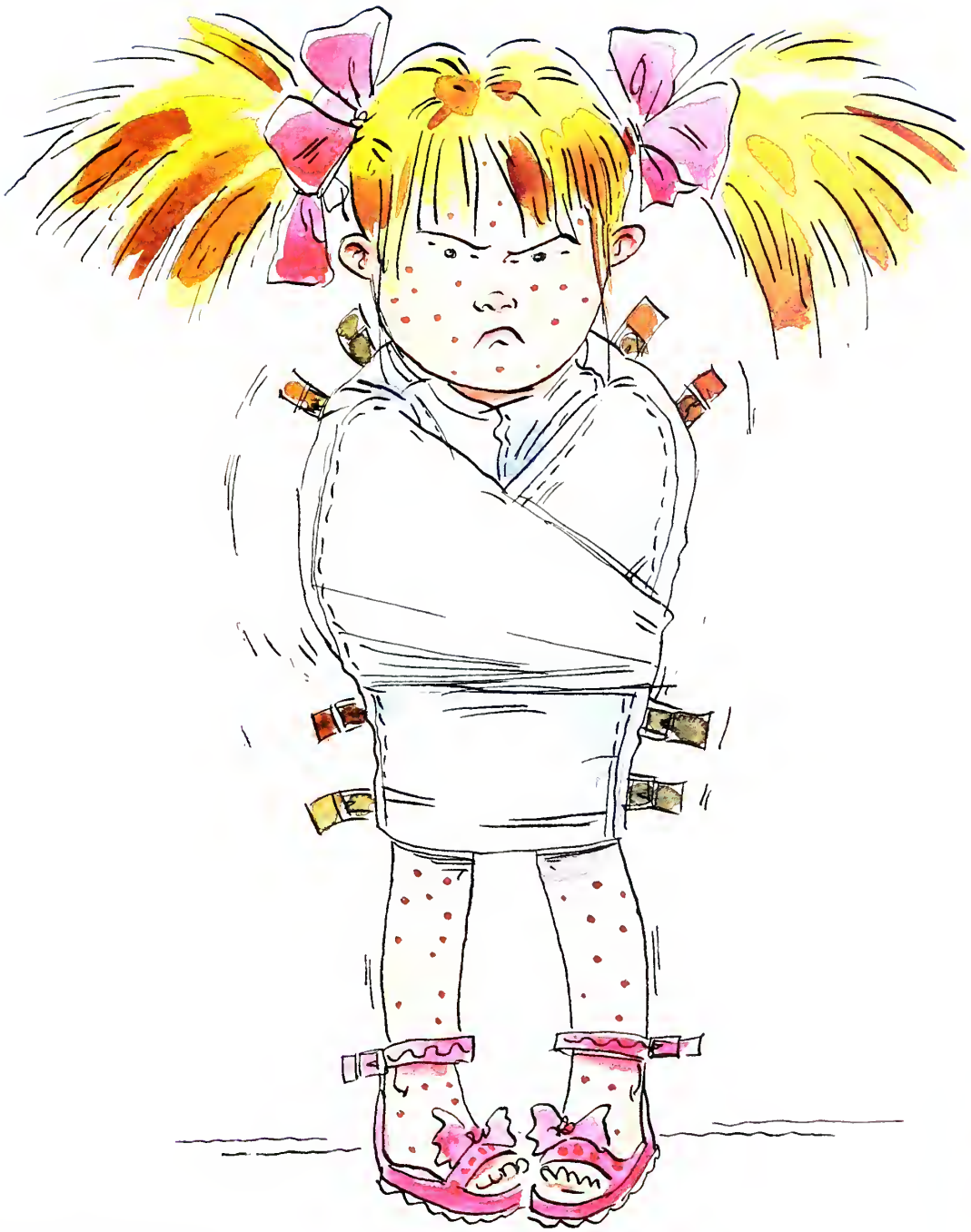

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Reference: 1. An open label study evaluating the efficacy and tolerability of Osmo 4 Gel in the management of itching associated with chickenpox, June 2009.

Supply chain problems and the use of automation to free pharmacists' time were the hot topics on the agenda on day two of C+D's Conference in Birmingham last week, reports **Jennifer Richardson**

C+D Conference: day 2

Mike Holden (chairman) (pictured standing)
Chief officer, Hampshire & Isle of Wight LPC
"What we need to do now is stop talking and find some solutions."

(pictured seated from the left) David Baker
Chief executive, Dispensing Doctors' Association (DDA)
"It's got to be the patient before commercial consideration – once we get that right at all levels of the supply chain it will work."

Graham Phillips
Independent Pharmacy Federation (IPF)
"We need a new, patient-centred vision [of pharmacy funding]."

John Turk
Chief executive, National Pharmacists' Association (NPA)
"The idea that the pharmaceutical industry in the free trade environment can control the whole supply chain is, frankly, a load of bollocks."

Jeremy Main
Managing director, Alliance Healthcare
"Where there's an opportunity to make money, people will take it."

Alex MacKinnon
Head of corporate affairs, Community Pharmacy Scotland (CPS)
"Patients are suffering and in Scotland we are not prepared to let that go on happening for very much longer."

David Fisher
Commercial director, Association of the British Pharmaceutical Industry (ABPI)
"Simply throwing more product at the market is not the answer."

No prizes for guessing what Mike Holden was talking about, introducing the Big Debate at C+D's Conference in Birmingham last week. "The situation is worsening and the problem is not being resolved. What we need to do now is stop talking and find solutions."

Medicines shortages have overshadowed community pharmacy life for over a year now, with pharmacists each spending several hours every week chasing around 50 vital drugs needed by patients.

Unfortunately, though, if the talking is anything to go by, the solutions could yet be some time coming, as the debate made clear that key players still cannot agree on the main cause of the problem.

One thing community pharmacy, wholesalers, manufacturers and dispensing doctors all agree is that there is a problem. And they also appear to agree with Dispensing Doctors' Association (DDA) chief executive David Baker that the problem is "multi-factorial". The problem arises when it comes to defining the relative roles of those factors. No one disagrees with Dr Baker that "the major problem is the fall in the value of the pound", but this is not something within their control.

For big pharma representative David Fisher, the most important issue to resolve is the amount of medicines intended for British patients that are exported to Europe. "The first step is to stabilise the system," said the commercial director of the Association of the British Pharmaceutical Industry (ABPI). "That means that when we supply medicines for UK patients, that at every point in the system the main aim is to get those UK medicines to UK patients."

But community pharmacy representatives reacted angrily to the implication that the problem was mainly caused by contractors, even a small minority, parallel trading for profit. It was "slightly disingenuous" to try to pin the blame on pharmacy, said NPA chairman Ian Facer from the floor. Mr Fisher responded: "There's nothing disingenuous about sharing our opinion. Community pharmacy is where the best data is and where the issue has been quantified; that's not to say it's the only issue."

For Community Pharmacy Scotland's head of

corporate affairs Alex MacKinnon, who estimated that just 5 to 6 per cent of Scottish contractors were exporting, the bigger problem was changes to the supply chain and manufacturer-imposed quotas. And, he added: "What I don't understand is how on earth some contractors who are exporting can get so much stock when others can't get one pack."

The Independent Pharmacy Federation's Graham Phillips agreed manufacturer-led supply deals were causing problems, estimating that the introduction of Pfizer's direct to pharmacy scheme two years ago had cost his Hertfordshire chain £10,000. "Is there a net increase in patient safety?" he asked. "I hardly think so."

However, in the wholesalers' corner, Alliance Healthcare managing director Jeremy Main backed the motives behind manufacturer-led supply deals. "My personal view is that [manufacturers] have brought them in to make sure there's continuity of supply to patients," he said. "The absolute fact is that where we are involved in newly configured supply chain models they do provide better levels of service." He also supported Mr Fisher's assertion that manufacturers were supplying plenty of product for the UK market.

Therefore, said Mr Fisher, manufacturers could not simply provide more product. "There's no lack of recognition that this is a serious problem," he insisted. "It's annoying, it's time-consuming, and it's downright dangerous. But I think we have to think carefully about the solution because simply releasing more product is not a sustainable answer. We still have leakages in the system that are stopping you getting that medicine on a sustainable basis."

Dr Baker called for all stakeholders to put aside money in trying to solve medicines shortages. "It's got to be the patient before commercial consideration," he said. "Once we get that right at all levels of the supply chain, it will work; until we get that, it won't." But this jarred with Jeremy Main's assertion that "where there's an opportunity to make money, people will take it – that's a fact", and the discussion predictably moved to funding.

Daniel Lee, managing director of online chemist Pharmacy2U, suggested from the floor that one solution was to reduce pharmacy's reliance on supply chain profit and instead remunerate the sector for quality of service. And Mr Phillips and Mr Turk agreed. "It seems to me that the system is now so broken as to be not fixable," said Mr Phillips. "We need a completely new vision of contract funding that puts patients first and rewards pharmacy for its clinical value. When we move in that direction this problem will almost solve itself."

"Automation I think is an absolutely key driver, whether that's automation in the pharmacy or outside of a pharmacy"

RICHARD SMITH, LLOYDSPHARMACY MD

A blueprint for success

Get ready to embrace technology. Whether you're a gadget whizz or more comfortable with books than bytes, it's time to bring community pharmacy up to date with robotics and online tools. According to Lloydspharmacy managing director Richard Smith, these will be "key drivers" of the sector for the future. Both automation and the internet will feed into the task at the top of Mr Smith's to do list for community pharmacy; inspiring consumers' trust in the sector. "What pharmacists have got and what they need to build on is the confidence of the consumer," he told the C+D Conference in Birmingham last week.

"Automation I think is an absolutely key driver," Mr Smith said, "whether that's automation in the pharmacy or outside of a pharmacy." Robotic dispensers may be viable in some high prescription volume pharmacies, but it's the possibilities posed by automation outside the pharmacy that Lloydspharmacy appears to be exploring with the greatest interest. As previously reported, the multiple has already supplied over one million items through the 'hub and spoke dispensing model', with 100 of its community pharmacies acting as 'spokes' to central dispensing 'hub' pharmacies (C+D, October 17, p10).

The importance of this is in freeing up pharmacists' time, which Lloydspharmacy is trying to do as much as possible because, Mr Smith said, "time is the biggest issue" in developing pharmacy for the future. "We have been very busy removing certain checks and tasks that aren't customer-related to try to increase the time our pharmacists can spend with customers," he said.

"What we have to do is find a reason why somebody would want to come to pharmacy. Supermarkets can be cheaper – I know because I worked there," Mr Smith continued, referring to his almost three decades at supermarket chain Somerfield. "They have got economy and they have got scale." And for Mr Smith, what will set community pharmacy apart and allow it to compete is face-time with, and advice from, health experts without the inconvenience of having to make an appointment.

But as well as finding the time to make this a reality, Mr Smith also believes the sector needs to "get our act together" and ensure quality. Last year's infamous Which? report, which found a third of advice given over pharmacy counters was "unsatisfactory", was, Mr Smith said, "a huge embarrassment".

Accordingly, he added: "A huge amount of investment goes into our staff training. We have to be clinical experts; we have to invest in training, we have to have all our staff who face the customer being able to give them confidence."

Funding continues to be a problem, Mr Smith vociferously argued (C+D, October 17, p5), with the dream of the sector being remunerated for service rather than volume still just that. But, he added, "perhaps if we get our act together as an industry, the tide may just be turning".

"This must be an opportunity for the Department of Health to use pharmacy cost-effectively to help reduce the rest of the burden on the NHS in the future.

"If we get the funding right I believe we have the opportunity to meet the demands of the consumer in the community."

Making the most of the internet will also be critical to positively boosting pharmacy's profile in the 21st century, Mr Smith believes. Lloydspharmacy has tapped into this potential with the launch and ongoing development of its online doctor initiative, in which internet surgery DrThom diagnoses and prescribes for a growing list of conditions and Lloydspharmacy supplies the prescription items.

And Mr Smith suggested it could take this one step further with Lloyd, an online personality for the Lloydspharmacy brand – a Lloydspharmacy avatar, for those familiar with the technological parlance – getting pharmacy face-time with consumers even when they're not in the pharmacy. "Whatever the consumer wants, when they want it, we need to provide it," Mr Smith said.

But that's certainly not to say technology can take pharmacists' place – far from it. Instead, Mr Smith believes it will allow them to prove the added value they can give to the traditional medicines supply service. One C+D Conference delegate asked Mr Smith what one thing she should do to take pharmacy into the future. His advice: "Get the pharmacist away from that task and be out front just to talk to consumers all the time."

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Look into locuming

Thought about becoming self-employed? **Chris Chapman** offers a guide to getting started

Locum pharmacists are the guns-for-hire of community pharmacy, filling gaps where needed and keeping pharmacies open. According to the RPSGB, about 37 per cent of community pharmacists work as locums, usually for higher rates than employed pharmacists. And as locums are self-employed they can decide when and where to work: they can do as much or as little work as they desire, or even work as a locum in addition to their regular job.

So how do you become a locum? Graeme Stafford, an experienced locum pharmacist, suggests you first need to consider whether you're up to the challenge. "The first thing to think about is how long you've been qualified," he advises. "If you've been qualified a long time, you've got the confidence to put yourself in any situation.

"When you're up in front and you're the man or woman in charge, you could be asked absolutely anything," he says.

You also need to consider the basic requirements that might be expected of you. Only pharmacists who qualified in the UK are allowed to be the responsible pharmacist in a pharmacy that's been open less than three years, so if you qualified abroad you might not be able to take every job on offer. It's also very important to have indemnity insurance in case the worst happens.

Once you're sure you want to do it, there are two ways to find a position. There are several locum agencies around the country that will find placements for eager pharmacists. Agencies do not charge locums a fee – they charge the pharmacy – but will make you sign a contract and you could work in almost any pharmacy.

However, Mr Stafford recommends budding locums start with the other route: by talking to pharmacists they know. "The best way is networking," he says. "Go and see people – don't go straight to agencies and be launched into somewhere that you have no idea about."

LocumVoice, a networking website for locum pharmacists, has a guide on how to work as a locum available to members. The guide suggests you attend local meetings and get to know other pharmacists in the area. Use every opportunity to tell people you are available for locum work, and contact local multiples to find out who is in charge of arranging locum cover. The LocumVoice guide also suggests printing business cards with your qualifications and mobile details, so people can contact you easily if work is available.

Before accepting a placement, check that you know what the situation will be when you arrive. The Society has a guide to working as a locum available on its website, which includes a checklist of the key things to consider before taking on a position (see Top tips for locums, above).

Mr Stafford also advises locums to visit the pharmacy beforehand to make sure they're familiar with the layout and work processes, or they could find themselves in a tricky situation.

"I turned up once on a Saturday morning when the pharmacy was having a refit," he says. "The guys were still drilling and things were falling on to the dispensary bench. Nobody had told me. You need to ask questions. Have they got the basic books there? The internet? Some larger chains will limit access."

Mr Stafford also highlights the importance of knowing the level of training of the staff that will be present. And the responsible pharmacist rules mean a locum needs to be familiar with the pharmacy's standard operating procedures (SOPs), as they will be responsible if something goes wrong. Locums also need to consider whether they will take a break, and whether they will be contactable during that break.

Lastly, it's important to think about money. According to LocumVoice, most multiples have different ways of paying locums, and it's important not to leave before you have completed their paperwork. The LocumVoice guide recommends you keep copies of all paperwork, and a robust system of organising bookings and ensuring you've been paid for your time.

Mr Stafford suggests a typical wage for a locum is around £25 per hour, and recommends pharmacists don't work for less than £23 per hour. "Don't sell yourself short," he advises. "If they know they can get you for £18, £19 or £21 an hour, it's very hard to argue differently later."

Locums are self-employed, and will need to do their own tax and National Insurance. Self-assessment is easy, although it's possible to hire an accountant to maximise all potential savings.

As a final note, the LocumVoice guide says there is one last thing to keep in mind: "A locum pharmacist who thanks the staff for their help and says goodbye, will most likely be asked back."

Top tips for locums

The RPSGB recommends that locums:

- keep a diary of all bookings, including cancellations
- ensure a contract exists between you and the employer, detailing what you will do
- contact employers to confirm dates and times
- check indemnity insurance is provided and you are covered
- check the location of the pharmacy and parking
- find out what computer system the pharmacy uses
- find out how experienced the staff on duty are, and how the pharmacy operates
- check how busy the pharmacy usually is, and what additional services are provided
- confirm you are eligible to be the responsible pharmacist if applicable
- remember to take your certificate and display it
- comply with tax and National Insurance requirements as a self-employed worker

Career tip of the week

"Ensure that your email address is professional when emailing employers. Names such as hotdan99@freemail.com or guesswho@freemail.com are likely to be viewed not only as unprofessional but potential virus carriers that may be deleted on receipt."

From Brilliant Job Hunting, by Angela Regan

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Postscript...

Mike Hewitson's diary of a new pharmacy owner

Lost in translation

It has been a week of misunderstandings.

First, on my return to work after a day off, my dispenser and counter assistant burst out laughing.

"What's so funny?" I asked.

"Just something that happened yesterday," she replied.

It turns out that they'd had an unusual request from the trainee assistant of one of the other shopkeepers in the town. She had asked for "two stereostrips and an immigrant". It was easy to see why they had burst out laughing – she had actually been sent in for some Steri-strips and Imigran! I'm glad that I wasn't there when she came in because I might have wet myself!

A couple of days later a patient came in to talk to me about her mother's tablets. She told me that she was taking "Nicaraguans".

Not again, I thought to myself. What could she mean? After a bit more questioning it turned out to be nicorandil for her angina!

On more professional matters, a major breakthrough has come in our relationship with one of the surgeries. I was asked to come and speak about a PCT waste management audit, which has now been postponed for the expected swine flu surge. Instead, we spent time talking about how the pharmacy could help them to get their budget balanced.

We are going to be offering targeted MURs to educate and reassure their patients who have recently had medicines changed (to save money). We will deliver this and show them what we can achieve.

> SHE TOLD ME SHE WAS TAKING "NICARAGUANS". NOT AGAIN, I THOUGHT TO MYSELF

Raiders of the lost archives

C+D 1859-2009 Celebrating 150 years in pharmacy

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What's the difference between rhubarb and opium? Not much, if you were a pharmacist in an unnamed Welsh town back in October 1860.

"The vicar of Clare, in Suffolk, has recently had a narrow escape from death," C+D announced to anybody who was interested. Apparently the lucky clergyman had been on a tour in Wales when he'd come down with a mystery illness and popped to the local pharmacy to get some tincture of rhubarb.

Unfortunately the vicar's request got a bit muddled, with the Welshman and the Suffolk gent struggling to understand each other – resulting in the pharmacist passing out laudanum instead.

Returning home, the vicar quaffed the whole bottle, only to notice the label and realise his mistake.

"Happily," reported C+D, "medical assistance was at once obtained, and the proper remedies applied, which eventually proved successful."

A sting in the tale

The Co-operative Group and pharmaceutical giant Bayer clashed earlier this month – over a film about bees.

Documentary The Vanishing of the Bees, which was released by the Co-operative, suggests that pesticides containing neonicitinoids, such as those produced by Bayer, may contribute to the mass death of bees around the world.

Paul Monahan, head of sustainability at The Co-operative Group , said it was "entirely possible, if not probable" pesticides were involved, insisting the Co-operative was not calling for a ban but for further research into the impact of pesticides on the environment.

However, Bayer spokesman Dr Julian Little told Postscript the film's claims were "an astonishing piece of fiction". He said: "If you're serious about bee health, you'll know they suffer varroa mites, fungus and viral diseases."

Postscript isn't that serious about bee health. And it's glad to know that, according to Mr Monahan, the tiff won't damage the relationship between Bayer and The Co-operative Pharmacy.

Rowlands team flock to help charity dig-in

Staff at Rowlands pharmacy's head office got their hands dirty last month when they volunteered to spring a Ground Force-style gardening makeover for charity.

Ten Alan Titchmarsh wannabes (pictured, with someone in an owl suit who presumably wasn't involved in the digging) descended on Linmere Visitors Centre in the Delamere forest, Cheshire, to spruce up its exterior.

The team dug, planted and pruned, before scattering some bark chippings for good measure.

The charity revamp was part of a team-building exercise at Rowlands head office, where different groups split up to help worthy causes around Runcorn. Other causes to benefit from the Rowlands team included a school and a care home.

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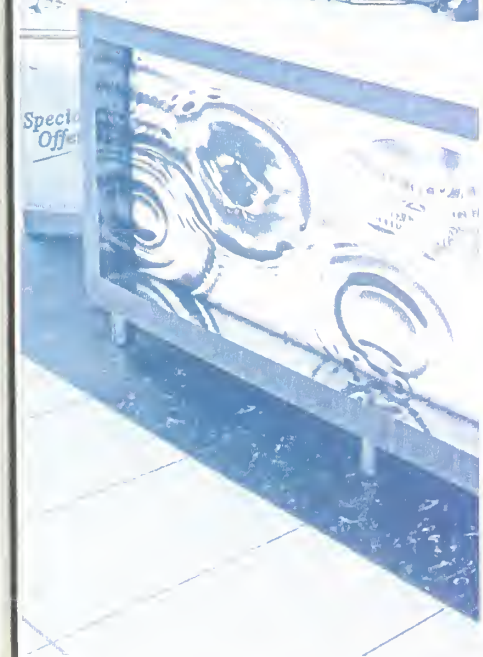

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When children need fast, effective relief from the symptoms of colds and flu, sore throats, aches and pains, recommend CALPROFEN. Nothing fights their fever faster or provides greater symptom relief throughout the night.

The makers of Calpol have kids' colds & flu covered this winter

Calprofen 100 mg/5 ml Oral Suspension Ibuprofen Product Information: Presentation: Suspension containing 100mg Ibuprofen per 5ml. **Uses:** Treatment of mild to moderate pain, antipyretic, post-immunisation pyrexia, symptoms of colds and flu and minor sprains or strains. **Dosage:** For Pain and Fever: *Infants 3-6 months, weighing over 5kg:* One 2.5 ml dose may be taken 3 times in 24 hours; *Infants 6-12 months:* 2.5ml three times a day; *Children 1-2 years:* 2.5ml three to four times a day; *Children 3-7 years:* 5ml three to four times a day; *Children 8-12 years:* 10ml three to four times a day. Post-Immunisation fever: 2.5ml (50mg) followed by one further 2.5ml (50mg) dose six hours later if necessary. No more than 2 doses in 24 hours. **Contraindications:** Hypersensitivity to ingredients, or to aspirin or other NSAIDs. Peptic ulceration, perforation or GI bleeding. Concomitant use with NSAIDs. Severe hepatic, renal or heart failure. Women in the last trimester of pregnancy. **Precautions:** The elderly; women tying to conceive; history of GI toxicity; concomitant medications increasing the risk of GI toxicity; hepatic or renal dysfunction; bronchial asthma or allergic disease; hypertension or heart failure; SLE and mixed connective tissue disease; chronic inflammatory disease. Not to be used in combination with anticoagulants, corticosteroids, lithium, methotrexate, zidovudine, diuretics and antihypertensives. **Pregnancy and lactation:** Not recommended. **Side effects:** Hypersensitivity, skin reactions, GI disturbances, oedema, hypertension, cardiac failure, exacerbation of asthma and bronchospasm, headache, haematological disorders. Rarely: hepatic dysfunction, peptic ulcer, perforation or gastrointestinal haemorrhage, acute renal failure, papillary necrosis, exacerbation of ulcerative colitis and Crohn's disease and symptoms of aseptic meningitis. **RRP (ex-VAT):** 200ml bottle £4.40; 100ml: £2.91. **Legal category:** 200ml: P; 100ml: GSL. **PL holder:** McNeil Products Ltd, Maidenhead, Berkshire, SL6 3UG. **PL number:** 200ml: 15513/0120; 100ml: 15513/0147. **Date of preparation:** July 2009. 04883

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